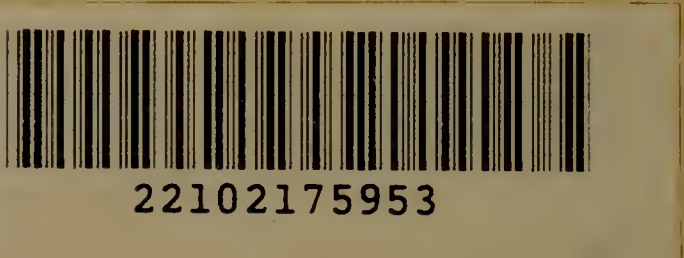

[illegible]ULES

OF SKIN PRACTICE.

BY

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"The Hair and its Diseases," etc.

"GOLDEN RULES" SERIES No. VIII.

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PREFACE TO SECOND EDITION.

THIS little book may be regarded as a kind of Skeleton Chart, the details of which must be filled in by the Student or the Practitioner, as time and opportunity offer. I have added as an appendix some new matter on *radio-therapeutics* in skin diseases, a subject which promises to be of no little importance in the near future.

D. W.

70a, Grosvenor Street, London, W.

INDEX.

Golden Rules of Skin Practice.

EXAMINATION OF PATIENT.

1.—Always examine your patient in a good light. Daylight is best, as colour is modified by artificial light, and faint rashes may be overlooked.

2.—See every part of the affected surface. Some rashes are multiform, and almost all may be altered locally by scratching, treatment, washing, and so on.

3.—Ascertain the duration of eruption, how and where it began, whether it irritates, whether any friend of the patient has a similar trouble, and what treatment has been adopted.

4.—Never neglect the family and per-

sonal history of the patient, which may throw a flood of light upon an otherwise obscure case. At the same time, never be tempted to give an opinion from the mere history of a case, or you may go sadly astray.

5.—Always investigate the state of the general health, even where the cause is purely local, *e.g.*, *scabies;* the results may be greatly modified by the constitution of the patient.

6.—Washing the skin may show the nature of an eruption by revealing scars, burrows, pigmentation and other objective evidence.

GENERAL.

7.—Remember that rashes may arise from food, as mussels and tainted meat, or from drugs, as antipyrine, the iodides, and antitoxin.

8.—The thermometer will often settle a diagnosis. Its use would prevent the confusion of a copaiba rash with measles, or of a vesicular syphilide with smallpox.

9.—Always examine the urine where the cause of the eruption is not evident. Chronic Bright's disease lies at the root of a number of skin troubles.

10.—Remember that more than one skin disease may exist in the same patient.

11.—Do not fail to think of the possibility of syphilis in doubtful cases or those which resist ordinary treatment.

12.—Always try and cure a skin disease as quickly as possible. Discourage the popular belief as to the danger of "driving a rash in."

13.—The only key to certain rashes in children may be found in the syphilitic history of the mother or father.

THE A B C OF SKIN DISEASES.

Remember the broad division of the lesions of the skin into *primary* and *secondary*. The primary vesicles of herpes zoster leave secondary scars.

PRIMARY LESIONS.

1.—*Macules* are discolourations of level skin of any size. They may be inflammatory (*hyperæmic*) or non-inflammatory (*nævus*); due to excess of pigmentation (*freckle*) or deficiency (*leucodermia*); or hæmorrhagic (linear *vibices*, punctate *petechiæ* or diffuse *ecchymosis*).

2.—*Papules* are solid elevations of the skin not larger than a pea. They may be inflammatory or non-inflammatory, and acuminate, round, flat or umbilicated in shape.

3.—*Vesicles* are elevations of the skin up to the size of a pea, containing clear or slightly turbid fluid.

4.—*Blebs* or *bullæ* are vesicles larger than a pea.

5.—*Pustules* are elevations of the skin containing pus, usually developed from vesicles.

6.—*Wheals* are flat, raised, solid elevations of the skin of a fleeting nature. They are rounded, with a pale centre and reddened edge.

7.—*Nodules* are papules larger than a

pea. [This name is better than tubercle, which is apt to be confused with tuberculosis.]

8.—*Tumours* are nodules of exaggerated size.

SECONDARY LESIONS.

9.—*Crusts* or *scabs* are dried products of diseased skin, such as blood, serum, pus and sebum.

10.—*Scales* or *squames* are plates of laminated epithelium shed from the surface by the process of desquamation.

11.—*Pigmentation* is common after many primary inflammations.

12.—*Excoriations* or *abrasions* are due to the removal of more or less of the horny layer of the skin; they are attended by serous discharge and the formation of brownish scales.

13.—*Ulcers* are caused by the inflammatory destruction of skin involving the corium; they end in scars.

14.—*Fissures*, *rhagades* or "*chaps*" are cracks extending through the epidermis.

15.—*Scars* or *cicatrices* follow destruc-

tion of the corium. They are formed of cicatricial tissue replacing the normal skin, and are usually depressed (atrophic). At times they may be elevated (hypertrophic) or pigmented.

NOTE.

The above lesions often merge one into the other; thus the small-pox papule becomes a vesicle and then a pustule, and finally ends in a scar. In herpes zoster the vesicles are primary, and the pustules and scarring secondary.

TREATMENT.

1.—**Remember** that while some diseases of the skin may be cured by external treatment alone, yet in the majority of instances internal treatment will be useful or necessary.

2.—**Do not forget** that some skin troubles tend to self-cure, as shingles and many slight forms of dermatitis. Others, such as ichthyosis, while incurable, may be relieved. Another class, again, is not only incurable, but is always fatal, *e.g.*, mycosis fungoides.

EXTERNAL TREATMENT.

1.—The great general rule of external treatment of curable skin disease is to stimulate dry and chronic conditions and to soothe the moist and acute.

2.—The chief stimulating agents are caustic potash, salicylic acid, nitrate of silver, carbolic acid, soft soap, iodine, blisters, sulphur, mercury, creolin, resorcin and other tar derivatives.

3.—The chief soothing agents are oxide of zinc, calamine, oleate of zinc, lead, simple ointment, vaseline, lanolin, carron oil, oleate of bismuth, weak preparations of carbolic acid, boracic acid, ammoniated mercury, hot baths.

4.—**Antiseptic** applications are of great and increasing importance in skin diseases, many of which are complicated by secondary septic processes.

5.—**Parasiticides** form an important class. The chief are sulphur, mercury, iodine, chrysarobin, carbolic and salicylic acids, resorcin and other tar preparations.

6.—**Remember** first to remove scales

and crusts before applying remedies. This may be done by soaking crusts in oil and poultieing, or by soaking the patient in a hot bath, and then scrubbing the skin with brushes or a Turkish glove.

7.—External remedies may be applied to the skin in the form of baths, soaps, lotions, powders, ointments, plasters.

8.—Powders may be astringent, soothing, drying, antiseptic, and are useful in moist conditions. Lotions are especially useful where other applications cannot be made during the daytime and in dealing with the hair. Ointments can be smeared over the skin or well rubbed in, or can be applied continuously on lint protected by oil-silk. A more thorough and prolonged contact can be secured by using the plaster-mulls of Unna, who incorporates various drugs in an adhesive mass spread upon thin india-rubber backed with muslin.

9.—Good caustics for the skin are pure carbolic acid, acid nitrate of mercury, nitrate of silver, arsenic, Coster's paste (iodine), Vienna paste, salicylic acid (the

last applied in Unna's plaster-mull, which is made up of various strengths).

10.—**Never forget** the possibility of absorption through the skin of certain drugs. Thus, cantharides absorbed from a blister may cause hæmorrhage from the kidneys. Mercury, even in the form of a weak ointment of white precipitate, may produce salivation and purging if applied to a large surface of skin. Fatal cases of poisoning have been reported from the use of perchloride of mercury lotions to the scalp.

11.—**Remember** that some skins rebel against certain drugs. Thus, more or less severe inflammatory dermatitis may be caused by the application of tar, iodoform, salicylic acid, sulphur, and other medicaments.

INTERNAL TREATMENT.

1.—**Remember** that "the best dermatologist is the best physician."

2.—**Investigate** the condition of the various organs of the patient, particularly as to the digestive tract and kidneys.

3.—**Remember** the excretory function of the skin, and relieve it when necessary by stimulating elimination by other routes, as by purging and diuretics. This end may be attained by the use of saline aperients conveniently in the form of a mineral water, as Hunyadi Janos.

4.—**Diet** should be regulated, and alcohol allowed only in strict moderation.

5.—**Bear in mind** that alteratives and tonics are sometimes invaluable; cod-liver oil may cure an inveterate acne, quinine a pruritus. Iron, nux vomica and tonics generally are sometimes of great service.

6.—**Do not fly** to arsenic in every case of skin disease. The less a medical man knows about that class of malady the more apt is he to use arsenic.

7.—The chief general conditions that affect skin maladies are gout, rheumatism, tuberculosis, malaria and syphilis.

Antimony.

This drug is sometimes recommended in eczema, prurigo and acute dermatitis.

9.—**Opium** and **morphia** sometimes give rise to erythematous, papular, vesicular, and other kinds of skin lesion.

10.—**Quinine** and other preparations of cinchona occasionally produce a rash, usually of an itching, erythematous or urticarious type, followed by free desquamation.

11.—**Antitoxin** rash is fairly common. Its simplest form is that of a fugitive scarlatiniform eruption; but it may assume urticarial, papular, and other types of more or less severity. A similar result has been noted in the case of *tuberculin*.

ECZEMA.

1.—**Eczema** is an inflammation, acute or chronic, of the skin, multiform, itching, and nearly always symptomatic.

2.—**Do not forget** that although its commonest form is characterised by vesicles and a weeping discharge that stiffens linen, with honey-like crusts, it nevertheless includes a great multiformity of lesions, as macules, papules, vesicles, pustules, scales and crusts.

3.—**Remember** that perhaps the most constant symptom is severe itching, which leads to scratching on the part of the patient, and serves to distinguish eczema from syphilis, psoriasis, and other affections.

4.—**Bear in mind** the causes are *external* and *internal* irritation. The great majority are external, as heat, friction, various chemicals and parasites. Internal causes are dietetic, medicinal, gouty, rheumatic, dyspeptic, and other more or less obscure predisposing and exciting conditions. A source of direct or indirect irritation may be found in most cases of eczema. An idiopathic catarrhal inflammation of the skin, to which the term eczema is confined by a few dermatologists, is extremely rare. The tendency of recent years has been to widen the definition of eczema far beyond the old restricted sense that defined it as a moist cutaneous inflammation.

5.—**Remember** that while the eczematous process is invariably complicated, if not caused, by micro-organisms in the

skin, yet there is no one specific parasite recognised. When the process is started in one part it may be inoculated in others by scratching. Secondary invasions by pus organisms are common. All these facts have an important bearing upon treatment.

6.—**Multiformity** furnishes a useful key to the understanding of eczema—multiformity of origin, of lesion, and of complication.

7.—**A great group** of eczematous troubles has been separated of late years under the name of seborrhœic dermatitis. In this type the multiform skin rash is associated with more or less marked inflammatory scaly condition, which is certainly due to the presence of one or more micro-organisms.

8.—**Never neglect**, therefore, in cases of eczema to examine and, if necessary, to treat the scalp.

9.—**Do not forget** that in a person with a predisposition to the malady, a small localised irritation of the skin or an acute dermatitis, due to some passing

cause, say a drug or a dyspepsia, may become a generalised and chronic eczema.

10.—**Remember** that scratching alone may keep up a chronic eczema for years.

11.—**Remember** that eczema is apt to run a rapid and acute course in babies and children.

12.—**Bear in mind** that the starting-point in children is often the "cradle-cap" or dried seborrhœic crust met with on the infantile scalp; secondly, that the irritant may be derived from the milk of the mother or wet nurse; that bromides cause a certain number of such cases; that irritant soaps or scabies may be at fault.

13.—**Do not confuse** eczema in babies with syphilis. In the latter the rash is frequent on the buttocks and "napkin area," and is associated with chronic coryza, snuffles, craniotabes, marasmus and other signs of infantile syphilis, together with a history of miscarriages and still births on the part of the mother.

14.—**Never forget** that eczema in young and old may be due to scabies;

this holds good for all classes of society, and may furnish the key to a life-long eczema. In some cases where eczema is said to be hereditary, the connecting link is simply the itch acarus.

15.—Remember that an exceedingly common cause of eczema in children is the presence of lice in the heads; the local inflammation started by scratching may become generalised.

TYPES AND VARIETIES OF ECZEMA.

1.—The four primary types are (*a*,) Erythematous; (*b*,) Papular; (*c*,) Vesicular; (*d*,) Pustular.

(*a*,) *Eczema erythematosum* shows itself as dry, diffuse, infiltrated patches of bright red or dusky colour, itching and chronic, with acute intermissions. It is often seen on the face of elderly people, who may rub off the outer portion of the eyebrows by constant scratching.

(*b*,) *Eczema papulosum* is one of the commonest and most chronic forms of the malady. It is characterised by a number of small red papules, about the

size of a pin-head, found in various parts of the body, especially where the skin is thick. They itch very much, and are often crusted with blood from scratching. They may pass into other forms of eczema, such as the vesicular and pustular.

(*c*,) *Eczema vesiculosum* is characteriscd by the appearance of small, closely-set vesicles, which speedily rupture and produce a discharge that stiffens linen (whereby it is distinguished from sweat) and forms crusts somewhat like honey. This form is preceded and attended with irritation. It was formerly the only condition recognisod as eczema, but is really not a common affection. It usually appears in places where the skin is thin, as between the fingers, the face, and between the breasts.

(*d*,) *Pustular eczema* may be regarded as the result of the invasion of one of the foregoing forms by pyogenic micro-organisms. The pustules appear in patches, which usually rupture and dry into a greenish crust. This constitutes contagious "impetigo." Children are specially prone to pustular forms of

eczema, often as the result of pediculi or scabies.

2.—Some of the chief varieties of eczema are:—

(*a*,) *Eczema squamosum*, in which small scales are found on an itching, infiltrated patch with ill-defined edges.

(*b*,) *Eczema seborrhœicum*, common on the temples or back of the ears in patches, often circular and well-defined, which may extend down the trunk (a descending dermatitis). The patches are covered with greasy scales, and itching is moderate. They are always associated with dry, thin hair, dandruff, irritation, and other signs and symptoms of seborrhœa of the scalp (see page 93), and yield rapidly to anti-parasitic treatment.

(*c*,) *Eczema rubrum* is a severe type of eczematous inflammation, in which there is formation of abundant scropurulent crusts and flakes upon a scarlet base. It may be caused by improper treatment of an ordinary eczema, and is commoner upon the legs and amongst elderly persons.

(*d*,) *Eczema marginatum* is an old name applied to patches with well-marked outlines. It is usually due to tinea tricophytina and other vegetable parasites.

(*e*,) *Eczema diabeticorum.* This distressing form occurs about the genital region of both sexes, as the result of sugar excreted in diabetic urine. It is attended with most severe itching (see Pruritus).

(*f*,) *Eczema intertrigo* is an inflammation between opposing folds of skin, as in armpits, bends of elbows, groin.

TREATMENT.

1.—**The golden rule** in the treatment of eczema is to soothe in acute cases and to stimulate in chronic.

2.—**Remember** that while treatment is chiefly external, there are many cases that require internal treatment for their cure.

3.—**Bear in mind** that to remedy dyspepsia and constipation is always important. A magnesia and iron mixture is valuable in many cases, with

bitter tonics, quinine, and sometimes cod-liver oil. Colchicum is useful in gouty patients, and salicylates in those of rheumatic tendency.

4.—Avoid soap in all acute forms of eczema. Wash with warm water, which is soothing, especially with the addition of oatmeal or starch. The oatmeal may be boiled in a bag and squeezed between the hands in the water to be used for washing.

5.—To soothe acute eczema powders are often beneficial, as:—

℞ Pulv. amyli - ℥j
Pulv. zinci oxidi ℥ij
Camph. pulv. - ℥ss
M. ft. pulv.

To the above 10 grains of salicylic acid may be added with advantage. A drachm of europhen is useful in suppurative cases.

When ointments can be borne, the following may be used:—

℞ Zinci oxidi - - - ℥ij
Ac. salicyl. - - - grs. v
Petrolati - - - ad ℥j
M. ft. ung.

LASSAR'S PASTE.

℞ Zinci oxidi
Amyli - - - āā ij
Vaselini - - - ℥iv

M. ft. pasta.

To this various antiseptics, as salicylic acid or resorcin (5 to 10 grs.) may be added. The paste should be spread thickly and covered with butter-cloth.

6.—To allay itching the best remedies are hot sponging and bathing, with the use of tar preparations, camphor, carbolic acid, carron oil, lead lotion. Camphor may be given in ointment, as in the foregoing paragraph; carbolic acid as a weak lotion—1 per cent. Carron oil may be applied continuously, and is better with the addition of 13 grains of pure carbolic acid to the ounce. Lead may be given in a lotion of the strength of 1 drachm of the liquor plumbi subacetatis to 6 or 8 ounces of rose-water; a lotion that may be improved by the addition of carbolic acid. Hot alkaline baths are of service, or baths prepared with creolin. An excellent

application is the lactate of lead made by adding a teaspoonful of liquor plumbi subacetatis to 4 ounces of fresh milk.

7.—In acute eczema of hairy parts lotions are often useful, or ointments made with vaseline.

8.—In dry, chronic eczema strong stimulation is needed. This may be obtained by sulphur, or in extreme cases by rubbing caustic potash solution into the affected surface, which is afterwards washed. The best remedies in chronic eczema are tar, salicylic and carbolic acids, mercury and sulphur.

9.—The best tar preparations are creolin, liquor carbonis detergens, resorcin, lysol, pix liquida, oil of cade.

An excellent all-round ointment for eczema is:—

℞ Creolin - - ℥ss
Hyd. ammon. - grs. x
Petrolati - - ℥j
M. ft. ung.

This can be made stronger if required by increasing the amount of the creolin

to a drachm, and by adding salicylic acid, grs. x—xxx to the ounce.

10.—When using the tar preparations in the form of lotion, it should be remembered that they are readily decomposed.

11.—The tar bath, of the strength of a drachm of creolin or of liquor carbonis detergens to the gallon of hot water, is valuable in many forms of subacute and chronic eczema.

12.—Remember that some skins rebel against tar.

13.—A rubber bandage will sometimes cure a chronic eczema of the leg.

ECZEMA OF SPECIAL REGIONS, AND ITS TREATMENT.

ECZEMA OF THE SCALP.

1.—Eczema of the scalp is usually pustular and crusted in infants, with inflammation and suppuration of glands. It is important to remove the crusts. In older patients always search most care-

fully for pediculi; when the eczema is due to that cause it is very apt to affect the occipital region and neck. Ringworm and syphilis should be carefully excluded. In syphilitic children there are often ulcers of the scalp; in seborrhœa there are fine scales (dandruff), an oily rather than a brittle crust, the hair is altered and falls out, and the backs of the ears are often involved.

2.—Remember that vaseline is the best basis for ointments of the scalp.

3.—Use a lotion when possible to the scalp, especially in the case of women.

4.—Pediculi may be destroyed by sulphur and mercurial ointments, and the ova by a solution of perchloride of mercury in spirit, 2 grains to the ounce, or by acetic acid.

5.—Do not allow applications to accumulate on the scalp of an infant; wash them off daily with warm water. The only exception is in acute weeping eczema, when an antiseptic powder may be allowed to remain for several days together.

ECZEMA OF THE AUDITORY CANAL.

This is often due to the invasion of a fungus. It may be treated by injection of weak boracic acid lotions and the blowing in of powders containing boracic acid, calamine, europhen and starch.

ECZEMA OF THE LIDS.

(TINEA TARSI.)

The edge of the lids is red and slightly crusted, and in long-standing cases the lashes are straggling and misplaced. Treatment consists in removing crusts and smearing the lids at night with a weak subnitrate of mercury ointment. Epilation may be required. The inflamed parts may be painted with a weak solution of nitrate of silver daily.

ECZEMA OF THE NOSTRILS.

This affection is chronic and often depends on the irritation of discharges from the nose. In children it may be connected with the chronic coryza and "snuffles" of inherited syphilis. In adults a chronic inflammation of the

upper lip may be caused by the eczema depending on nasal discharge. Treatment consists in antiseptic sprays appropriate to the nasal condition, and the passage of soft, soothing and antiseptic unguents into the lower part of the nostrils by means of a pledget of cotton wool on the end of a match. Plugs soaked in astringent and antiseptic lotions may be required.

ECZEMA OF THE LIPS.

1.—Labial eczema is familiar in the form of "chaps" or painful fissures. Ointments of oxide of zinc, subacetate of lead, or boracic acid are useful by way of treatment. The cracks may be painted with compound tincture of benzoin, or a weak solution of silver nitrate.

2.—Syphilis must be carefully excluded. When it affects the lips there are usually mucous patches inside the mouth, while other signs of the disease may be found elsewhere.

ECZEMA OF THE BEARD.

Often called non-parasitic sycosis to distinguish it from that due to fungi of

the trichophyton group. In eczema the hair is not loose; pustules, when present, are not perforated by single hairs; it often affects neighbouring parts, and no fungus is found under the microscope. Sulphur, dilute nitrate of mercury, or weak oleate of mercury (2 to 5 per cent.) ointments are useful. In the day-time a powder may be used of boracic acid, salicylic acid, and starch. The author has had brilliant results from exposure to the X-ray focus tube.

ECZEMA OF THE BREASTS AND NIPPLES.

1.—An intertrigo is sometimes found between the breasts of stout women (see next section).

2.—Remember that a common site of scabies is about the breasts and nipples of women.

3.—The nipples may be inoculated with syphilis, and the resulting chancre be accompanied with a bubo of the axilla.

4.—Eczema of the nipple, with painful cracking, is met with in nursing women. A thick layer of Lassar's paste on muslin

is a good application. Cracks may be pencilled with compound tincture of benzoin or weak nitrate of silver solution, or with a 2 per cent. salicylic acid collodion. India-rubber nipple-shields may be used.

5.—Chronic eczema of the nipple is a malignant papillary dermatitis known as "Paget's disease." Its parasitic origin has not been established. Eventually it develops into an epitheliomatous growth that invades the breast. In advanced cases nodules may be felt in the mamma, and enlargement of axillary glands. The best treatment is early and complete removal of the breast.

ECZEMA OF THE GENITALS.

1.—**Remember** this is a most obstinate and distressing disease, which may be confined to the scrotum, the labia majora or minora, or involve the perineum and anus.

2.—**Always** exclude pediculi pubis.

3.—**In every case** examine the urine for sugar.

4.—In women examine for leucorrhœa, and for hæmorrhoids in both sexes.

5.—Hot baths are useful, especially with the addition of creolin, 1 drachm to the gallon, or baths made with starch, bran or linseed meal.

A creolin ointment is valuable in scrotal eczema, and may be combined with hyd. ammon. (grains x, ad ℥j). In women mild mercurial and lead ointments, with boracic acid lotions, may be used.

6.—The writer has found it a good plan to order daily washing of the parts with white soap, and then dusting on two or three times in the day the following powder:—

℞ Pulv. zinci ox. - ℥ij
,, ac boracis - ℥j
,, ac. salicyl. grs. xv
Amyli - - - ad ℥j
M. ft. pulv.

At night apply an ointment of carbolic acid and ammoniated mercury, each 10 grains to the ounce of vascline.

ECZEMA INTERTRIGO.

This is a severer form of the more common erythema intertrigo between opposing surfaces of skin, as armpits, bends of elbows, etc. (see Intertrigo).

ECZEMA SEBORRHŒICUM.

This important class of eczematous inflammation is described under seborrhœa.

ECZEMA TROPICUM.

(Prickly Heat.)

This condition is produced by exposure to heat, and is common to many people on first encountering the heat of the tropics. There is hyperæmia of skin, with sweating, and various papular or vesicular eruptions. Treatment consists in a saline purge and cooling application.

VARICOSE ECZEMA.

This variety is met with in the legs, associated with varicose veins. This is the only ulcerating form of eczema. In addition to ordinary treatment, it is necessary to elevate the limb and to relieve the dilated veins by an elastic stocking or by operation.

ERYTHEMA NODOSUM.

1.—**Remember** that this is a disease closely connected with rheumatism. It occurs as a rule in patients under twenty years of age, and in females twice as often as in males.

2.—**Remember** that the symmetrical, tender, non-suppurating, cutaneous nodes do not always occur over the shins and insteps; they are met with at times on the thighs, forearms, and rarely on the face and back.

3.—The nodes—a form of exudative erythema—appear suddenly as red, oval, elastic swellings, from one to three inches in length, along the axis of the limb. After ten days or a fortnight they fade away and resemble bruises. They are constantly associated with pain and swelling about the joints.

4.—Treatment for this not very serious affection consists in rest, with elevation of affected parts, and bandaging with a rubber bandage.

FEIGNED DISEASES.

Remember that malingering is met with in the case of the skin among men-

dicants, soldiers, inmates of public institutions, and hysterical females. The points to bear in mind are: (*a*,) the eruption is asymmetrical; (*b*,) it is usually on parts that can be readily reached by the right hand (if right-handed), *e.g.*, left forearm and right thigh and leg; (*c*,) it is on an unusual site and not of any recognised type; (*d*,) it does not get well under ordinary remedies, but heals when shielded by a plaster case. Various agents have been used to excite eruptions, such as carbolic acid, croton oil, tartar emetic, ointment, tar, sulphate of copper, copper coins, and simple continued friction with a moistened finger.

FURUNCULUS.

(See Boils.)

HERPES.

The meaning of this term is now restricted to groups of vesicles on a red base. Three varieties are usually described:—

(*a*,) Herpes zoster, or shingles.
(*b*,) Herpes facialis.
(*c*,) Herpes progenitalis.

All are of neurotic origin, but while *herpes zoster* follows the distribution of a sensory nerve and occurs as a rule only once in the same patient, the other two have no distinct nerve distribution and are recurrent.

A.—HERPES ZOSTER, ZONA, OR SHINGLES.

1.—**Remember** that this acute inflammatory eruption may affect almost any of the cutaneous nerves other than the intercostal.

2.—**Bear in mind** that severe intercostal neuralgia may be the forerunner of shingles.

3.—**Remember** that the administration of arsenic is definitely connected with attacks of intercostal herpes.

4.—While the eruption is usually unilateral, it may be symmetrical. In rare cases shingles may develop on both sides of the chest, but there is no more danger in the double than in the single form.

5.—**Always** warn a patient that scarring is often exceptionally severe in

herpes zoster of the supraorbital branch of the fifth nerve. It is important to note that scars may follow simple herpes about the region of the eyes.

B.—FACIAL HERPES

Usually occurs as a small patch about the lips, often ushered in by shivering or chilliness, and followed by a rise of temperature. Often met with in pneumonia, simple catarrh, tonsillitis, and other inflammations.

C.—HERPES PROGENITALIS.

Never mistake this for syphilis. It occurs on the genitals of both sexes, and in the male is known as H. præputialis. The vesicles scab over and drop off as a rule in about a week. When irritated, however, by sexual intercourse or by treatment with caustics, they may ulcerate and persist for weeks and be attended by enlarged inguinal glands. In early cases the group of vesicles on a red base can be recognised at a glance; when ulceration has ensued it sometimes requires great care and patience to distinguish the lesion from a soft sore. Be

guarded in your diagnosis if any doubt exists. The herpetic ulcer improves rapidly under mild antiseptic treatment, and usually has a history of recurrent attacks.

ICHTHYOSIS.

1.—Remember that ichthyosis is a congenital and chronic disease, rarely curable, and apt to be complicated by eczematous inflammation. It runs in families, and often affects the children of one sex.

2.—The chief varieties are:—

(*a*) *Xeroderma ichthyoides*, when the skin generally is dry, thick in places, with the natural lines more marked than usual, with spiny follicles (keratosis pilaris), a tendency to "chaps" and a constantly dirty skin.

(*b*) Ichthyosis, a general thickening and harsh dryness of the skin, with epidermic scaling of various degrees, from small scales to rough, granular, greenish, or even blackish scaliness, resembling the skin of a fish, snake or crocodile. The malady attacks chiefly extensor surfaces, and legs are worse than arms.

The flexures usually escape, and sweating is found in them ; the palms and soles escape, but are smooth and shiny.

3.—Treatment is not satisfactory. Baths may be used, and mild antiseptic ointments rubbed in to increase the suppleness of the hide-bound skin. Secondary eczemas require appropriate remedies. Hot air sometimes cures.

4.—Recently thyroid gland has been found to influence this condition. The writer has met with considerable and sometimes lasting success in treating ichthyotic children by that drug.

IMPETIGO CONTAGIOSA.

1.—Remember this is essentially a disease of childhood, although it may be communicated to mothers, nurses, and others. It is due to direct invasion by pyococcic organisms, usually of the staphylococcic group. The lesions begin as discrete patches of vesicles or vesicopustules without an areola, and are covered by loose yellow or greenish crusts. They are common on the face and are highly contagious, being spread

rapidly through families and schools. In weakly children the disease is apt to run riot, owing to the small powers of resistance to invasion, and the process becomes more or less generalised through auto-inoculation, sometimes with the formation of large blebs without inflammatory areola (as in pemphigus).

2.—Treatment is simple: remove the crusts by carbolised oil and boracic compresses, and apply ammoniated mercury ointment, 10 grains to the ounce. Cod-liver oil and tonics are often valuable.

INTERTRIGO OR CHAFING.

1.—Remember that ordinary intertrigo is an erythema, and the fluid excreted from it does not stiffen linen as in eczema.

2.—Intertrigo is met with where any folds of skin are in contact, as in armpits, bends of arms, back of knees, groin, perineum, breasts of women, the buttocks or groins of babies.

3.—Do not confuse intertrigo of the napkin area with syphilis in infants;

the syphilitic lesion often extends down the legs and up the trunk.

4.—Intertrigo appears to be often connected with seborrhœa of the scalp. It may develop into a papular or pustular eczema intertrigo, with circumscribed abscesses in axilla, etc.

5.—Treatment consists in washing night and morning with soap and water. During the day an antiseptic dusting powder may be freely applied, with an ointment of creolin, ammoniated mercury and boracic acid at night.

KELOID—TRUE OR ALIBERT'S KELOID.

1.—Keloid is a firm, elastic, fibrocellular overgrowth of the deeper skin, often shaped like the claw of a crab—hence the name. It is usually divided into scar-keloid and spontaneous keloid, but it may be doubted if the latter does not always originate in some remote injury. The typical scar variety may follow small-pox, syphilides, boils, prickly heat, and other trifling eruptions. Acne keloid usually disappears in the course of time.

2.—**Never attempt** to remove a keloid by operation, as it almost invariably recurs. Treatment is of little avail. Epithelioma may develop on scar keloid, when it should be excised at once with a wide and deep incision.

LICHEN PLANUS, or L. RUBER PLANUS.

1.—An eruption characterised by small, red papules, the size of a pin's head to a lentil, discrete or confluent, acute or chronic and itching. The typical papules have a bluish tint, a shiny surface, angular outlines, and often lie in the long axis of the limb. They are commonest on the front of the wrists, forearms, lower abdomen, lumbar region, neck, legs, genitals, palms and soles, but may occur elsewhere. Patches are often found on the tongue and mucous lining of the mouth.

2.—**Remember** that when confluent patches of lichen planus are found, there are always outlying typical papules, bluish, shiny and angular, and sometimes umbilicated.

3.—Bear in mind that the eruption of lichen ruber planus is apt to be followed by more or less deep pigmentation, which is commonly confused with syphilis. The papular syphilides are usually scaly and do not itch. There is a ringed form of lichen planus that is most misleading; its distinctive features are brownish pigmentation of an area within a collar of shiny, flattened papules, often umbilicated. The ringed syphilide, on the other hand, has ordinary papules and a papule situated in the centre of the ring.

4.—Remember that lichen may last for many years, and be much modified in its appearance by a chronic inflammatory condition (lichenification) of the skin.

5.—External treatment alone will suffice to cure a great many cases; any of the more stimulating tar, salicylic acid, sulphur and mercurials may be used. Isolated lesions may be treated with salicylic collodion or chrysarobin ointment. Internal treatment may be necessary, and a great number of drugs have been lauded for the purpose.

LUPUS VULGARIS.

1.—Remember it is your duty to recognise and deal promptly with lupus. Every case can be checked at its outset, and the terribly scarred and deformed faces resulting from this disease are unnecessary, and constitute a grave reproach to the medical attendant.

2.—Bear in mind that lupus is a localised skin tuberculosis of an extremely chronic nature, dependent on the presence of the tubercle bacillus. It is a disease of youth, and usually appears before ten years of age, rarely after puberty.

3.—The lesion of lupus begins as a small "apple-jelly" papule that does not disappear under pressure. It enlarges and may join other papules until a nodule is formed, or a sharp-defined patch with apple-jelly nodules at edge and scaly, scarred or ulcerating centre. The tendency is to ulcerate and to extend indefinitely, destroying cartilages, but not bone, and ending in scars. The process is painless, asymmetrical, and may involve the mucous membrane of nose, eye

gums and larynx. Always examine these parts, especially the mouth. It is common on the face, but may be met with on the hands, feet, buttocks, and almost any part of the body.

4.—Lupus vulgaris is sometimes mistaken for lupus erythematosus, syphilis, and epithelioma.

5.—Lupus erythematosus is symmetrical, occurs after puberty, has no apple-jelly nodules, does not affect cartilages, is non-ulcerative, and scars lightly. The nodular syphilide occurs in adult life. It is apt to attack bone, is accompanied by other signs of syphilis, lacks the defined ring of "apple-jelly" lupus nodules, and runs a quick course compared with lupus. Epithelioma is a disease of later life; it has a hard, everted edge and a foul base, often studded with warty or "cauliflower" growths. The neighbouring lymphatic glands are involved at an early stage, and all deep tissues are invaded and destroyed. Rodent ulcer is a very slow ulcerative process, having a smooth base and raised edge; common about the eyelids in old people.

6.—Remember that the treatment of lupus is early and thorough eradication by surgical measures. Caustics may be used, but they are not so satisfactory as more radical treatment. The most useful are the chloride of zinc or the arsenical pastes, solid nitrate of silver ploughed into the nodules, acid nitrate of mercury, and the creasote and salicylic acid plaster-mull. Complete and wide excision gives good results where the lesion is limited, but recurrence may take place in the scar. Multiple scarification succeeds well at times. The best treatment, however, is to scrape thoroughly with a Volkmann's sharp spoon, after which the tissues should be mopped freely with strong nitric acid or the acid nitrate of mercury, and dressed with iodoform. The Röntgen rays have been widely used for the treatment of lupus; good results are always obtainable, but the remedy has to be applied by skilled hands. This treatment possesses the great advantage over ordinary methods that a cutting operation is avoided. The active agent is almost certainly not the Röntgen rays

themselves. The nasal cavity, if attacked by lupus, may be scraped out and treated with caustics. A few cases heal well under tuberculin R treatment. Finsen's light treatment often cures permanently.

7.—Remember that the course of lupus is marked by waves of activity.

8.—Internal treatment is needed in some cases. After existing for many years in a localised form, the tuberculosis may appear in the lungs and other parts of the body.

LUPUS ERYTHEMATOSUS.

1.—Bear in mind that no micro-organism has been identified in this condition.

2.—Lupus erythematosus begins as erythematous points that fade on pressure; these spread slowly and coalesce with others to form superficial patches, which do not ulcerate, which are extremely chronic, non-irritating, symmetrical, and atrophy in the centre, with formation of a faint scar.

Remember that lupus erythema-

tosus occurs chiefly between the ages of twenty-five and forty-five. It most commonly attacks the face, and is symmetrical on the cheeks and lobes of the ears, and is often seen on the neck and scalp. Its shape is compared with that of a bat—the body on the nose and the wings on the cheeks. It is sometimes met with on the hands and feet, and rarely on other parts of the body. In any of the latter situations it is frequently mistaken for syphilis. On the hands it resembles a chilblain, but the latter goes away in summer, while lupus erythematosus is chronic and persistent.

4.—In the early or erythematous stages the disease is best treated by lead and calamine lotions and soothing treatment generally. Later, when there is less hyperæmia, the part may be rubbed with green soap, or with Hebra's spiritus saponis kalinus (equal parts of soft soap and spirit). In chronic cases resorcin collodion (10 per cent.), or mild salicylic acid plaster may be tried. Should this treatment not effect a cure, the parts may be scarified by multiple linear surface excisions, followed by mild anti-

septic ointment. Internal remedies are of little use.

5.—Remember that lupus erythematosus of the scalp leaves patches of permanent baldness.

MILIARIA OR SUDAMINA.

This occurs as an eruption of small vesicles caused by obstructed sweat ducts, often closely set together, but rarely confluent. The eruption usually lasts for a few days and ends in desquamation, but may occur in successive crops and give rise to more or less itching. The most common site is the trunk, but any part may be affected. When inflamed (miliaria rubra) the lesion is the strophulus or red gum of the older writers. This form is apt to be mistaken for an exanthem, and it should be borne in mind that sudamina occurs in many fevers, especially in typhoid. Another form is the miliaria papulosa of mingled papules and vesicles, known as "prickly heat," and more correctly perhaps described here than as a papular eczema. Little or no treatment is needed for sudamina

except, perhaps, soothing powders or lotions in the inflamed varieties.

MOLLUSCUM CONTAGIOSUM.

1.—Remember that this disease is contagious, although only in slight degree, and may be caught in Turkish baths or from towels.

2.—The *molluscum* is a small, waxy-looking papule, varying from a pin's head to a pea, or larger, umbilicated in the centre, and often yielding a sebaceous material on pressure. It is of slow growth, non-irritating, and occurs often in large numbers on the face, scalp, hands, and other parts of the body.

3.—Molluscum sometimes inflames and suppurates. It is uncommon on the penis.

4.—The disease is commonly attributed to invasion of epithelial cells in the follicles by animal parasites of the class sporozoa and group coccidia. The oval "molluscum corpuscle" found in the tumour is the result of a transformed epithelial cell.

5.—Treatment is simple: the small

papules may be pricked with a needle dipped in pure carbolic acid. Pressing out the contents will sometimes effect a cure. Mild cases may be healed with salicylic or carbolic acid and sulphur ointments. Incision and touching with nitrate of silver or carbolic acid may be required in the more advanced cases.

6.—Never be too heroic, for in most cases molluscum will heal spontaneously without scar in the course of time.

MORPHŒA

Is a circumscribed sclerodermia or hardening of the skin, which is extremely rare as a general condition. It is characterised by white or "ivory" patches or bands with a pink or violet border. It is extremely chronic, painless, and fresh patches in many cases appear as the older ones disappear. It is little influenced by treatment.

NÆVUS.

The chief varieties are :—

(*a*,) Pigmentary.
(*b*,) Vascular.

(*a*) 1.—The pigmentary is caused by a deposit of pigment, with or without tissue hypertrophy. Moles vary much in size and colour, and may be flat or elevated; some are covered with hair. If irritated, moles may become malignant, especially the warty kinds. Hairy moles may be removed by free plastic incision; if small they may be destroyed by electrolysis.

2.—Never attempt to destroy moles by caustics.

(*b*,) 1.—The vascular mole may be divided into capillary and venous; in both they are due to dilatation of cutaneous capillaries.

2.—The capillary nævus is common on the face. It may vary in size from a pin-point red or purple point to a large stain the size of a hand, or involving a whole limb. As a rule, the blood may be squeezed out by firm pressure, and the colour then returns slowly.

3.—The venous tumour is prominent, smooth or lobulated, pulsatile, soft and easily compressible. It sometimes affects mucous membranes, and extends deeply into adjacent tissues. The cover-

nous forms (angioma) sometimes grow rapidly and involve large areas, when they may cause death by hæmorrhage.

4.—Never neglect prompt and radical surgical treatment of the venous pulsating nævus; in the early stage this can be done with ease and safety by ligature or electrolysis.

5.—The capillary nævus can be treated when small by puncture with the electrolysis needle, or by touching with nitric acid, first protecting the surrounding skin with vaseline. If this precaution be not taken a lasting scar is liable to result. Larger nævi may be treated by multiple linear scarification or by electrolytic punctures.

PEDICULOSIS.

Three varieties of lice infest different parts of the human body, namely, (*a*,) the head, (*b*,) the body, and (*c*,) the pubic hairs. They all give rise to intolerable itching, and feed by inserting a sucker into the opening of a sweat duct, which, after the process, fills up with blood, and makes a hæmorrhagic red speck on the

surface. The main secondary lesions, parallel abrasions, hæmorrhages, and pus-inoculations are due to scratching. The head-louse has a triangular head, and is midway between the body-louse, which is longest, and the pubic-louse, which is broadest. All three varieties are capable of very rapid multiplication; their ova hatch in a week, and are sexually mature in a fortnight. No sex, age, or condition is free from invasion. In some instances general skin eruptions, suppurating glands, and other more or less severe complications follow their inroads.

A.—PEDICULUS CAPITIS.

1.—**Remember** that the commonest site is the occipital region.

2.—**Always** search the scalp for "nits," if there are enlarged glands the nape of the neck or behind the ear.

3.—**Remember** that many eczematous and pustular states of the scalp, especially in children, are due to lice.

4.—**Carefully distinguish** between scales and "nits." The ova are fixed

firmly to the hair, and can be made to slide along the hair-shaft, while the scale, even when pierced by the hair, is readily detached.

5.—Remember that careful search in the thick hair at the back of the head will sometimes reveal a "nit" or two where it would be impossible to find any lice.

6.—The pediculi can be killed and the skin troubles treated by a single application, such as hyd. ammon., ac. carbol. pur. āā grs. x, to the ounce of vaseline.

7.—The "nits" are more difficult to destroy, but either of the following may be used:—

℞ Acid. acetici - - ℥ij
Hyd. perchlor. - grs. iij
Aq. ad - - - ℥viij
M. ft. lotio.

℞ Ætheris pur. - - ℥j
Hyd. oleat. (5%) - ℥j
M. ft. applicatio.

8.—The hair may be cut short in children; it is unnecessary in adults.

9.—Never tell a patient that he (or she) has lice in the hair unless you can produce convincing proof in the shape of a louse or a "nit." This rule applies to all forms of pediculosis.

B.—PEDICULUS CORPORIS.

1.—Broadly speaking, body-lice affect old people who are badly nourished and poorly circumstanced.

2.—The itching may be general, while the lice may be on one spot.

3.—The most favourite site is the nape of the neck and shoulders. The lice and the small yellowish ova are found on the clothing, especially about the collar-band.

4.—The affection is known by the intense itching, worse at night, by the hæmorrhagic specks, the scratch-marks on the neck and shoulders, and the presence of pediculi and ova on the clothes.

5.—Treatment consists in thorough disinfection of clothes and bedding by heat, applied in an oven or disinfecting apparatus, or by means of scalding water. At the same time lotions of carbolic

acid, of creolin, oxide of zinc and ammoniated mercury, and hot antiseptic baths are useful.

6.—Remember that a leathery and pigmented skin may result from the chronic irritation of pediculi. It is met with in tramps, and is known as "vagabond's disease."

C.—PEDICULUS PUBIS.

1.—Although its chief site is the pubes, this louse invades the axilla and other parts of the body.

2.—Remember that some chronic forms of blepharitis in children are due to the presence of the pediculus pubis upon the roots of the eyelashes.

3.—Itching is the chief trouble, but eczematous inflammations may occur.

4.—Any mild mercurial ointment will soon kill the pediculi. Both nits and lice are killed by the æther and oleate of mercury application given under pediculus capitis.

PEMPHIGUS.

Pemphigus vulgaris is a somewhat rare eruption, acute or chronic, charac-

terised by the sudden appearance of successive crops of bullæ on the face, trunk, limbs, and other parts of the body. A few of the acute cases are attended with fever and end fatally. Some cases of acute pemphigus have been ascribed to invasion of micro-organisms; the pemphigus that attacks new-born children appears to be due to infection of that kind. Such cases do well and must be carefully distinguished from the bullous syphilide. On the whole, it is well to give a guarded prognosis in pemphigus. Arsenic is much lauded in this disease, but is often disappointing. Local treatment is necessary, but can hardly be called curative.

PITYRIASIS RUBRA.

1.—This is a rare inflammatory condition of the whole surface of the body, characterised by deep redness, with abundant flabby desquamation. It is well to give a guarded prognosis. The eruption is symmetrical, rapid, universal as a rule, and the affected skin is scarlet with scales of varying size, often thin, wafer-like and overlapping, sometimes of

great size, so that casts of the hands and feet may be thrown off. The scales are always loose and distinct, and do not form crusts. There is little or no itching, but some stiffness and heat of skin are felt. Pityriasis rubra may occur as a primary affection, but is often secondary to psoriasis, eczema, lichen ruber planus, and other dermatites. Mild soothing and antiseptic local measures, with abstinence from alcohol and careful attention to the general health, constitute the treatment.

2.—Remember that in severe cases of pityriasis rubra the general health may be seriously impaired, or death may result

PRURIGO.

In this disease the essential feature is the scattered pale papule, which is irritable and becomes red, inflamed, and tipped with a blood-crust as the result of scratching. It commonly begins in infancy, and is complicated with wheals, when it is known as *lichen urticatus* or infantile prurigo. The papular form may last all the patient's life. The skin becomes thickened, and feels like a nut-

meg grater, especially on the outside of the arms and thighs; at the same time the lymphatic glands of the groin and elsewhere may be greatly enlarged. It appears to affect chiefly those of arthritic and neurotic tendency. Hebra regards the condition as incurable, but fortunately that is not the experience in Great Britain. *Internal treatment* comprises iodide of iron, cod-liver oil, iodide of potassium, mineral waters, and so on. Externally, cod-liver oil has been much lauded. Tar-baths are useful, conveniently in the strength of 1 drachm of creolin to the gallon of hot water. Creolin, liquor carbonis detergens, combined with ammoniated mercury, salicylic acid and other antiseptics, may be applied in the form of ointments; sulphur may be used in chronic cases. As treatment has often to be patiently applied over long periods of time, it is well to change the applications from time to time. Remember that all, or nearly all, cases are curable.

PRURITUS.

1.—Remember that pruritus is a symptom. Strictly speaking, its defini-

tion includes only that kind of itching that is without obvious cause; that is to say, it is a pure sensory neurosis. These may be spoken of as (*a*,) *general* and, where an obvious irritant is concerned as (*b*,) *local* pruritus.

2.—Remember that pruritus may be scratched into general dermatitis.

3.—Never conclude that a case is one purely of pruritus until you have carefully excluded every possible source of external irritation.

4.—A certain number of patients suffer from the fixed delusion that they are infested with lice, itch, and so on.

A.—GENERAL PRURITUS

May be divided into:—

(1,) Pruritus universalis.
(2,) Pruritus hiemalis.
(3,) Pruritus senilis.

(1,) *Pruritus universalis* is met with in such disorders as gout, rheumatism, cancer, gall-stones, dyspepsia, uterine and ovarian disease, diabetes, liver derangements and pregnancy.

(2,) *Pruritus hiemalis* is a form that occurs in the winter, and is worse when the patient gets warm in bed.

(3,) *Pruritus senilis* is an incurable disease met with in old people, usually after the sixtieth year. The skin shows little signs of the violent scratching to which it is subjected.

B.—LOCAL PRURITUS.

1.—Pruritus ani may be due to the presence of hæmorrhoids, scybala in the rectum, fissures, worms, fistula, urethral stricture, and so on.

2.—Pruritus of the vulva may be due to ovarian, uterine or vaginal disease, or in young subjects to thread-worms; in older patients it is very commonly due to sugar in the urine.

3.—Pruritus of the male genitals (scrotum, penis, etc.) may be due to local causes, such as stricture, or urine containing sugar; or it may be part of a general pruritus.

TREATMENT.

1.—**Remember** that the treatment of pruritus is likely to test the skill of the

medical attendant to the utmost. It is a distressing malady, difficult to cure, and in some cases even to relieve.

2.—Internal treatment includes diet and everything that can remedy any defects of the digestive and other systems of the body. Of drugs, arsenic is useless, while valeriante of ammonia, cannabis indica, anodynes, bromide of camphor, gelsemium, carbolic acid, calcium chloride, and quininc are more or less useful

3.—External Applications. Baths, plain and medicated, of hot water or hot air, are sometimes of service. The best drugs are creolin, resorcin, carbolic acid, and ichthyol, mopped in warm lotions over the part. Powders of salicylic acid, oxide of zinc, starch, and camphor may give relief. Ointments of oxide of zinc or calamine may be combined with local sedatives. The writer has had some excellent results with high frequency electrical treatment.

4.—The local varieties of pruritus, especially of the anus and vulva, demand the cure of local morbid conditions. Con-

stant cleanliness, simple washing with soap and water twice daily, and the constant application of a dusting powder of calamine, salicylic acid and starch will cure slight cases. Medicated tampons are necessary in some forms of pruritus vulvæ. In extreme cases electrolysis, thermo-cautery and applications of carbolic acid or nitrate of silver solution may be tried.

PSORIASIS.

1.—Remember that psoriasis is a chronic disease characterised by dry, slightly raised, red, rounded patches, crusted with silvery white scales.

2.—The rash is symmetrical, and begins as small papules which enlarge into discs, rings and festoons. It commonly attacks the scalp and the extensor surfaces of the limbs, especially the knee (over the ligamentum patellæ) and the tip of the elbow (over the olecranon); it may or may not itch.

3.—A characteristic of the psoriasis patch is the bleeding points revealed by scraping away the silvery scales.

4.—There is a family predisposition towards psoriasis; at any rate the disease, if strongly marked in a parent, is pretty sure to be reproduced in one or more children.

5.—Remember that psoriasis often attacks strong persons, and is often associated with a history of gout. At the same time, debilitating causes, such as prolonged nursing, may bring on attacks.

6.—Psoriasis is sometimes acute: it occurs in red patches that grow quickly and are covered with yellowish desquamating flakes (not fine, imbricated, silvery scales). The eruption is always dry, which distinguishes it from eczema. The acute form is apt to spread over the whole body, and is then known as pityriasis rubra.

7.—Do not confuse psoriasis with the scaly syphilide of early secondary syphilis. In the latter the scales are scanty and dull-looking, bleeding-points are not disclosed by scraping the patch; elbows and knees are not specially attacked.

8.—Psoriasis is no longer regarded as

one of the commonest of skin diseases, chiefly because a great number of chronic scaly rashes are now traced to a seborrhœic origin. In the psoriasiform seborrhœic dermatitis the patches are not on the elbows and knees; the scales are greasy, yellowish, and do not cover the *whole* patch with a crust of silvery scales as in true psoriasis. In the seborrhœic form the lesions are often multiple; for instance, there may be an intertrigo of the armpit, and seborrhœa will be found on the scalp.

TREATMENT.

1. — **Always** warn a patient that although the psoriasis may be cured for a time, it will almost always return sooner or later.

2.—Treatment is both *internal* and *external*; most cases, however, can be cured by local treatment alone if carried out thoroughly.

A.—Internal Remedies.

1.—Arsenic is no longer regarded as the sheet anchor in psoriasis. In a few cases only does it appear to have a cura-

tive effect; in others it is distinctly harmful, while in the majority its results are negative so far as the skin is concerned.

2.—Some cases improve rapidly under thyroid gland; a 5-grain tabloid may be given daily at first, and cautiously increased to thrice that amount.

3.—Salicylate of soda acts well in a few cases, but, like other internal drug treatment of psoriasis, is disappointing in the majority of cases.

B.—External.

1.—Always remove the scales before applying external remedies. This may be done by soaking and scrubbing in a hot alkaline bath (℥iv sod. carb. to an ordinary bath), or a hot creolin bath (℥j of the creolin to the gallon of water).

2.—The most convenient external remedies are tar and mercury; creolin is an excellent tar preparation, and may be applied in the form of ointment, ℥ss or ℥j to the ounce of vaseline, to which grs. x of ammoniated mercury may be added. If the scales be excessive

salicylic acid is useful (grs. x to the ounce).

3.—Chrysarobin or chrysophanic acid, are most powerful remedies, and may be used in obstinate cases; they stain linen and are apt to cause a severe dermatitis. Patients must be warned never to touch the face with their hands while either drug is being used. or they may excite a violent conjunctivitis. On this account neither remedy should be used for the face or scalp. A good plan is to apply it daily as a paint, of the strength of 20 grains to the ounce of traumaticin (pure gutta-percha, 1 part dissolved in 9 parts of chloroform). Salicylic acid may be added to this paint.

4.—Remember that the ammoniated mercury, although a mild application, may produce mercurialism if applied to large surfaces or over a long period. (This point is often overlooked in practice.)

5.—Always treat the scalp. Mild mercurial ointments, as the well diluted nitrate of mercury, are useful. Resorcin is a good application, or a soft soap

lotion (Sapo mollis ℥j to Sp. Vini Rect. or Aquæ Cologniensis ℥ij), to which a drachm of creolin or liquor carbonis detergens may be added.

6.—Bear in mind that all cases of psoriasis are curable, but in no disease of the skin is thoroughness of treatment more essential. Success depends to a great extent upon the choice of remedies, and the skilful alternation of stimulating and of soothing action.

PURPURA.

Remember that hæmorrhages of the skin, when not due to external causes, *e.g.*, violence, are symptomatic of some underlying and often obscure diseased condition. The idiopathic hæmorrhages, as they are called, may be divided into (*a*) P. simplex, (*b*) P. hæmorrhagica, and (*c*) P. rheumatica.

A.—PURPURA SIMPLEX.

A number of bright hæmorrhages of varying size appear suddenly, often in the night, and most commonly on the backs of the legs and thighs. The eruption is symmetrical, and causes no

inconvenience; it comes out in crops which last from a few days to several weeks. Little or no treatment is required, but iron and ergotin may be useful in the more severe cases.

B.—PURPURA HÆMORRHAGICA.

This is a more severe form known as land scurvy, often preceded by headache and debility, and sooner or later attended by internal hæmorrhages from mucous and serous membranes. Any and every part of the body surface may be involved by crops of hæmorrhages of various aspect. Bleeding may take place from nose, lungs, stomach, kidneys, and into the cavities, as the meninges, where death may ensue from pressure, or the patient may die of exhaustion. In less severe cases the bleeding may cease suddenly in two or three weeks. Absolute rest in bed, with turpentine and ergotine internally, are the chief points in treatment.

Remember that simple purpura may develop into the more severe form with internal hæmorrhages; the prognosis should therefore be guarded.

C.—PURPURA RHEUMATICA.
(Peliosis.)

In this affection the purpuric rash is attended with pains in the joints and sometimes a rise in temperature to 100° F. or 102° F. The eruption may be hæmorrhagic and flat from the first, or appear as slightly raised papules or patches, from a hemp-seed to a florin in size, bright red and unaltered by pressure, later becoming of a bluish tint. The attack is often accompanied with much debility and depression; it lasts usually two or three weeks, but is extremely apt to recur. It is more common in women than in men, and usually affects young adults. Treatment consists in the salicylates, iron, ergot and cod-liver oil internally.

RODENT ULCER.

1.—Remember that although the most common site for rodent ulcer is near the inner canthus of the eyelids and the sides of the nose, yet it may be met with also on the scalp, forehead, neck, chin, the limbs and the breast—

indeed, wherever there are hairs and sebaeeous follicles.

2.—Rodent ulcer in its early stages is a new growth, not an ulcer, and is now regarded as a form of earcinoma. It is peeuliar, however, in the extreme slowness of its growth, in its not being disseminated by lymphatics, and in its non-reeurrenee af er complete removal.

3.—Always bear in mind, then, the necessity of thorough exeision of rodent uleer.

SCABIES or ITCH.

1.—Remember that the acarus seabiei eauses an eruption of multiform nature, eonsisting of vesicles, papules and pustules. This is often modified and masked by a seeondary dermatitis due to scratching.

2.—Search for the eharaeteristie burrow beneath the skin, with the minute white dot at the end marking the aearus.

3.—Remember that a chronic eczema may be due to unsuspeeted seabies. So-called hereditary eezema may be simply inherited itch.

4.—Bear in mind that scabies, if untreated, may go on for a lifetime, and that no class of society, high or low, is exempt from the disease.

5.—Next to the discovery of the burrows, the multiform lesion and the itching (worse at night), the most important sign is the site of the eruption, from which alone the rash may often be diagnosed.

6.—Remember the characteristic sites of itch. Roughly speaking, it chiefly affects body and limbs below the level of the elbows. The favourite sites are the thin skin between the fingers and the hands generally, the wrists, more so on the ulnar side, the armpits, notably the anterior fold; the breasts in women, especially round the nipple, the penis, the front of the abdomen, and near the umbilicus; the folds of the buttock; the ankles and soles in children and old-standing cases. Pustular and scabbed eruptions occur over the ischial regions of cobblers and others who sit for long periods at a stretch. The face and scalp are attacked only in children, who are

infected from the breast of mother or nurse; infants are also apt to be infected on hips and feet from the hands of attendants.

TREATMENT.

1.—In severe cases first cure the eczematous eruption, then treat for scabies.

2.—The essentials of treatment are: (*a*) to open up burrows, (*b*) to kill the acarus, (*c*) to prevent re-infection.

(*a*) Let the patient scrub himself with soft soap for half an hour in a hot bath.

(*b*) Let him then rub himself thoroughly with sulphur ointment for half an hour and go to bed without removing the ointment.

(*c*) Disinfect all clothes and bedding by boiling or baking.

3.—**Remember** that your remedies (*e.g.*, sulphur) may themselves inflame the skin.

4.—**Bear in mind** that all scabies is curable, and that re-infection is the chief cause of failure.

5.—**Do not overlook** such things as gloves, mittens, socks, scarves, muffs.

mantles (sleeved), great coats (cuffs), bedding and towels.

6.—Sulphur is the sovereign remedy for itch. It may be used in a strength of half a drachm of sublimed sulphur to the ounce of vaseline, combined with an equal quantity of oil of cade. Penetration may be aided by the addition of the subcarbonate of potash. When sulphur is too irritant to the skin, the ointment of stavesacre or β-naphthol (a drachm to the ounce) may be substituted.

SEBORRHŒA.

Strictly speaking, seborrhœa means an affection of the sebaceous glands, with an increase of their secretion; the more modern use of the the term, however, has far outgrown that definition. The undoubted relation of seborrhœa to many rashes of the body renders it a condition of importance. The most recent British views appear to be that seborrhœa oleosa may be a pure, oily hyper-secretion, either physiological, as maintained by Unna, or the result of a specific micro-bacillus, as held by

Sabouraud. Seborrhœa sieca, on the other hand, is now universally regarded as an infective microbial malady, as a rule grafted upon the oily seborrhœa.

1.—SEBORRHŒA OLEOSA.

This affection is characterised by a layer of oily, greasy matter upon the sealp. It is also common about the nose and eheeks, less rarely on other parts of the face. The gland ducts are open and visible to the eye, while slight inflammation of the nose, small varieose vessels and aene are usual accompaniments.

There is a more advanced form of oily seborrhœa in which dirty, greasy crusts are formed on the scalp: they consist of sebum and epithelial scales upon a moist and reddish surface. This variety often spreads to the temples and skin near the scalp.

2.—SEBORRHŒA SICCA.

This is really a pityriasis of the scalp, of whieh the scales are mainly epithelial. This is the parasitie and contagious varicty.

The subject of seborrhœa is still im-

perfectly understood. Upon different parts of the body the rash may take the form of dry or greasy desquamating patches, or as diffuse or circumscribed patches of greasy crusts upon a more or less inflamed skin. A common form is a number of round or ringed fawn-coloured, slightly desquamating patches on chest and back, especially between the shoulders and over the sternum.

A recent writer has remarked of seborrhœa sicca that it is accompanied in nearly all cases by a special type of constitution, and that its natural termination is a form of baldness, beginning in the temporal and frontal regions, and quite distinct from ordinary coronal baldness, although occasionally associated with it. He also agrees with Unna and others that seborrhœa favours the epiphytic development of certain affections, such as acne vulgaris, acne rosacea and seborrhœic dermatitis, and probably also of lupus erythematosus and pityriasis rubra (Anderson).

Remember, then, that dry seborrhœa of the scalp may be at the root of various

skin rashes of the rest of the body, and that its development greatly depends on the constitution and state of health of the individual. The practical application of these facts are: (*a*,) Always examine and, if necessary, treat the scalp; (*b*,) Attend to the individual constitution; (*c*,) Use local antiseptics vigorously.

SYCOSIS

Is an acute or chronic inflammation in and about the hair follicles in regions where the hair is coarse, as the beard and moustache, eyebrows, and more rarely the axillæ, pubes, and even the thighs. It was formerly divided into so-called parasitic and non-parasitic sycosis, but both are really parasitic. The old-fashioned "parasitic sycosis" is due to tricophyton, and will be mentioned under ringworm of the beard. The old "non-parasitic" form will be spoken of as sycosis. It is due to the invasion of the follicles by *staphylococcus aureus*, *albus* or *citreus*, and possibly by other pyogenic organisms. It is often a most intractable affection, and on the

upper lip is nearly always connected with nasal catarrh. Sycosis is characterised by an eruption of papules, pustules and nodules, each of which is perforated by a hair at some period of its existence. There appears to be some state of the constitution that renders it vulnerable to the invasion. Sycosis is often mistaken for eczema; but in the latter the inflammation does not begin in the hairs, is not as a rule confined to hairy parts, the hairs are not loosened, there is weeping and much irritation, and no formation of scars. Ringworm of the beard begins slowly, and rarely has pustules perforated by hairs. The fungus can be found with the microscope round the root of the hair. Treatment consists in plucking loose hairs out of pustules. Mild antiseptic and soothing ointments, such as subnitrate of bismuth, ℈ a drachm, and carbolic acid, ♏ v. to ʒj of vaseline. A 5 per cent. ointment of oleate of mercury is often valuable, and very mild sulphur ointments are often useful at the outset of treatment. More chronic stages require stronger remedies. In sycosis of the

upper lip the nasal catarrh may require treatment. The general health may need attention.

SYPHILIS.*

1.—**Remember** that almost every kind of known cutaneous eruption may be imitated by syphilis.

2.—**Do not** expect the "raw ham" colour in all papular and tubercular syphilides.

3.—One of the most marked features is the mixed nature of the eruption.

4.—In doubtful cases try the effect of anti-syphilitic remedies.

5.—The secondary eruptions are in the main symmetrical, the tertiary non-symmetrical and scar-leaving.

6.—In cases of doubt examine the mouth and throat for inflammation, mucous patches and ulcerations; the eye for iritis; the glands, especially of groin and neck; the nervous system for cerebral syphilis and so on; the bones for nodes

* This subject is so wide that only one or two points have been dealt with.

and other periosteal thickenings; the joints for inflammation; the testicle, liver and other organs for gummata.

7.—**Remember** that many rashes of congenital syphilis in babies are mistaken for erythema, eczema, intertrigo, and other non-specific ailments. This is not likely in typical cases where the child is wasted, *café-au-lait* colour, wrinkled, old-looking, hoarse, snuffling, thin-haired, with rashes about the skin and especially the buttocks, mucous tubercles and fissures about the mouth and anus, with later craniotabes, periosteal thickenings and epiphysitis.

8.—**Remember** that nasal obstruction and a history of early coryza may be the only evidence obtainable of inherited syphilis.

9.—**Look out** for the triad in later congenital syphilis: deafness, interstitial keratitis, and the notched and pegged teeth of Hutchinson.

TINEA TRYCOPHYTON OR TONSURANS.

1.—**Remember** that the ringworm fungus is now divided into two main

groups, the small-spored and the large-spored.

2.—Roughly speaking, about one-third of the cases of ringworm in children is due to the large-spored variety, which is seen as filaments or chains inside the hair. The point is of importance, as the large-spored variety is much more readily cured.

3.—Remember that ordinary small-spored ringworm of the scalp is often most rebellious to treatment, and may last for many months, or even years, in spite of the utmost care and skilled attention.

4.—Never pronounce a case cured until no more fungus can be detected by the microscope. In doubtful cases it is better to use a special stain for the detection of the fungus.

5.—Remember that re-infection from the patient's head covering or dressings may spread the infection; order a paper or linen covering that can be destroyed or disinfected daily.

6.—Ringworm on hairless parts (tinea circinata) can be readily cured.

7.—**Remember** that in severe cases the patient may require general treatment, such as cod-liver oil and iron.

8.—**Do not use** too powerful applications, as they may cause permanent baldness or chronic dermatitis.

9.—Stimulate or soothe according to the condition of the lesion. Remove crusts and treat secondary pus invasions when present.

10.—**Never** allow a child suffering from ringworm to attend school; such a patient is suffering from a highly contagious and obstinate malady.

TINEA BARBÆ or RINGWORM OF THE BEARD.

This is generally due to a large spored tricophyton. Its treatment is by epilation and parasiticides, such as sulphur, oleate of mercury, and chrysarobin.

TINEA FAVUS.

Remember the distinguishing point about favus is the sulphur coloured cup, which is pierced by a hair when small. It leaves permanent scarring and attacks the skin on any part of the body. The

branching fungus can be readily distinguished under the microscope.

TINEA VERSICOLOR.

These little fawn-coloured patches are common on the chest. They are sharply defined, roundish, slightly scaly, sometimes a little irritating, scattered or confluent, most commonly met with on the trunk.

Do not mistake them for secondary syphilides; the microscope will settle the point at once.

URTICARIA.

1.—**Remember** that the wheals of urticaria appear suddenly and disappear in an equally rapid manner; a patient may have nothing to show the medical man.

2.—Do not forget that there is always a cause for urticaria, and it is the duty of the medical man to search systematically for the origin of the malady. It may be due to articles of diet, to drugs, to disorders of the alimentary canal, the genital or other organs.

3.—In the most chronic cases a cure may be anticipated in the long run.

APPENDIX.

RADIO-THERAPY IN SKIN DISEASES.

A new field has been opened up by the application of Röntgen methods to diseases of the skin. Whether the active agency lies in the rays themselves or in the electrical field around the focus tube has not yet been determined.*

Some diseases can be definitely cured by exposure to the active focus tube. These are rodent ulcer, lupus vulgaris, and superficial cancerous affections

As regards **malignant affections of the skin**, many cases of cure have been recorded in epitheliomatous growths. It has been equally well established that nodules of recurrent cancer after operation, as a rule, may be made to disappear by exposure to the focus tube. The influence of the tube upon **deep-seated tumours** is doubtful. Pain and

* The present writer inclines to the view that the effects are due to an *effluve* or kind of invisible brush discharge given off from the tube.

tenderness, however, can almost always be reduced or abolished.

The high frequency electrical treatment promises better results in the less superficial malignant growths. Good observers have reported apparent cure in accessible **sarcomata**, and improvement or apparent cure in recurrent and inoperable **carcinomata** generally. The high frequency current, where it does not cure, invariably brings relief. It induces sleep, improves appetite, lessens or abolishes pain, and improves the patient's condition in various ways, local and general.

The writer has cured **granular lids** in a few weeks with the high frequency current. Equally brilliant results in the same disease have been obtained with the focus tube. It seems not unlikely, indeed, that a great future awaits both these methods in dermatology.

Epilation by the focus tube has been advocated. It is, however, uncertain, tedious, and not without risk; and has never taken the place of electrolysis. It has been found useful in favus (Norman

Walker), and the writer has found it at times most valuable in ringworm.

Chronic and severe **acne**, **chronic eczema**, **psoriasis**, **warts**, **mycosis fungoides**, may all be benefited by the focus tube. Indeed, that method may reasonably be tried in most chronic and obstinate skin diseases.

The writer has found most excellent results in **sycosis**, the treatment of which has been shortened by months.

The focus tube treatment may in most cases be advantageously combined with surgical and other ordinary treatment.

It may be used in cancerous growths, both before operation, to limit the field of invasion, and afterwards to prevent recurrence (Morton).

All electrical treatment should be placed in the hands of a **medical expert**, otherwise the medical attendant incurs a serious responsibility in case of bad results, to say nothing of the loss of a skilled supervision and report upon his case.

The **Finsen light-cure**, or photo-therapy, although tedious in application, nevertheless yields excellent results in **lupus**. The *arc light* is now used largely instead of sunlight. Future developments probably await this valuable advance in therapeutics.

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